

CONJOINT PSYCHOTHERAPY FOR MEDICATION COMPLIANCE AND SYMPTOM  
STABILIZATION

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By

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## Abstract

### CONJOINT PSYCHOTHERAPY FOR MEDICATION COMPLIANCE AND SYMPTOM STABILIZATION

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Medications can be a life saver for those suffering from Bipolar Disorders. Many individuals with this disease resist treatment due to the side affects of the medication or the individual may have lost hope. It may take years to find the right dosage of medication to end the horrible mood swings, but once the right medications and therapy are found, it can bring back the balance to the individual's life. Psychotherapy is an important addition to medication. Many approaches, types, of therapy are proven to be very useful. Psychotherapy helps the individual to adjust to the reality of this illness. It is crucial for the individual to be compliant with both suggested treatments. Treatment helps with mood stability, social stability, and overall, life stability. While there is no cure for Bipolar Disorder, it is highly treatable and manageable.

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## CHAPTER I

### INTRODUCTION

Bipolar Disorder society affects approximately 5.7 million adult Americans (DBSA 2006). Bipolar disorder requires lifelong treatments, even when the conditions have subsided. The most common treatment is medication. While medications are necessary to stabilize mood, additional interventions could improve lives of many consumers.

#### **Statement of the Problem**

The problem to be addressed is the importance of medication compliance, the importance of mood stabilizers in conjoint with psychotherapy treatments.

#### **Definition of Terms**

**Bipolar Disorder-** "Bipolar disorder, also commonly known as manic depression, is a brain disorder that causes shifts in a person's mood, energy, and ability to function. The symptoms of bipolar disorder can result in damaged relationships, difficulty in working or going to school, and even suicide. There are generally periods of normal mood as well, but left untreated, people with bipolar disorder continue to experience these shifts in mood. The good news is

that bipolar disorder can be treated, and people with this illness can lead full and productive lives. (American Psychiatric Association, 2011)

### **Delimitations of Research**

The references used for the review of literature were collected over a period of 91 days using the resources of the Karmann Library at the University of Wisconsin. The several search engines provided by EBSCOHOST were used. The key search terms were "Bipolar Disorder", and "Alternative Medication for Bipolar Disorder".

### **Method of Approach**

A brief review of the history of Bipolar as a mental disorder was conducted. A review of literature relating to research, studies, and anecdotal evidence of alternative medicine, and its impact on Bipolar Disorder, as well as coping with society and relationships with these coping mechanisms. Another review of literature on related research was conducted. The findings were summarized and synthesized, and recommendations made.

## **Chapter II**

### **REVIEW OF LITERATURE**

## Symptoms/ Criteria of Bipolar Disorder

Bi-polar disorders often go unrecognized by the patient, relatives, friends and sometimes physicians. It is part of human conditioning to have emotional rises and falls, yet experiences become "abnormal" when those experiences are being pushed into extremes of depression or mania. When diagnosing Bi-polar Disorder; it is not as simple as diagnosing the common cold. This diagnosis takes time as well as a careful analysis of a patient's mental, medical and family history. Many symptoms of Bi-polar Disorder mimic other psychiatric conditions. This is why it is very important to take the time to rule out other psychiatric conditions. To further complicate diagnosing Bi-polar Disorder, most of the other mental disorders can also occur with Bi-polar Disorders such as Attention Deficit Hyperactivity Disorder, Alcohol/Substance Abuse, Borderline Personality Disorder, Delusional Disorder, Depression, and many others.

Bi-polar Disorder symptoms may appear and look very different in different individual's lives. These symptoms vary widely in their frequency, pattern and severity. Some individuals are more vulnerable to either their mania or depression, while others may alternate equally between the two types of episodes; mania and/or depression. While on the other hand, others may have frequent mood disruptions, or may only experience a few disruptions over a lifetime. There is no simple physiological test to confirm Bi-polar Disorder. In particular, it can be

difficult to distinguish depression caused by Bi-polar Disorder from pure uni-polar depression. Since there is not a concrete guideline to the symptoms of Bi-polar Disorder in order to solely diagnosis this disorder off of symptoms, the state provides a criteria to meet for all mental health disorders.

The Diagnostic and Statistical manual of Mental Disorders (DSM) is an updated published manual by the American Psychiatric Association, which has an official set of diagnostic criteria for all mental disorders in the United States. This manual is set up in different categories which then generally correspond to the international categories used in the International Classification of Disease published by the World Health Organization. The DSM is used and relied upon by many health and clinical professionals. The current DSM is organized into a five part axial system. Axis I incorporates the clinical disorders (ex: ADHD, Anorexia, Bi-polar Disorder, Depression, Learning Disorders, Mental Retardation, Panic Disorders, etc.) Axis II breaks down the general clinical disorders into two categories, Personality Disorders and Intellectual Disabilities. The continued axes cover medical, psychosocial, environmental, and childhood factors functionally to provide a diagnostic criterion for health care assessments.

When meeting the criteria for Bi-polar Disorder, according to the DSM-IV, there are four different types of Bi-polar Disorders. Each specific type of Bi-polar Disorder is separated from others through the nature of

episodes that the individual has experienced. Bi-polar I Disorder requires at least one manic or mixed episode, yet may have mixed episodes of hypomanic or major depression. The DSM-IV-TR diagnostic criteria for this first category would either consist of 1.) Mood episodes which are not better accounted for by Schizoaffective Disorder and are not Superimposed on Schizophrenia, Schizophreniform Disorder, Delusional Disorder, or Psychotic Disorder not otherwise specified. 2.) The mood symptoms cause clinically significant distress or impairment in social, occupation or other important areas of functioning. Lastly, mood symptoms are not due to the direct physiological effects of substance (a drug of abuse, a medication or other treatment) or a general medical condition (Code 296.0x, 296.40, 296.4x, 296.5x, 296.6x, 296.7x). The second type is Bi-polar II Disorders. The diagnosis of this disorder requires neither a manic or mixed episodes, yet requires at least one episode of hypomania in addition to a major depression episode (Code 296.89). The third type of category is the Cyclothymia Disorder. The diagnosis of this disorder requires a history of numerous hypomania episodes intermingled with numerous episodes of depression that do not meet the criteria for major depressive episodes (Code 301.13). The last category for meeting the criteria for Bi-polar Disorder is Bi-polar Disorder Not Otherwise Specified. This category includes disorders with Bi-polar features that do not meet the criteria for any specific Bi-polar Disorder (Code 296.80).

## Chapter III

### REVIEW OF LITERATURE

#### History of Diagnosis

The early history of Bipolar Disorder and other mental disorders was considered a manifestation to ignorance, misunderstanding and a fear to this disease. Around the era of 300 to 400 AD, some individuals with Bipolar Disorders were at times euthanized. "Some early documentation viewed individuals with this disorder as "crazy" or possessed by the devil and demons", stated Dr. Gardenswartz. Then, the punishment or treatment included restraints or chaining; their blood was drained; they were given different potions, or electric eels were applied to their skulls. Many times, witchcraft was used to "cure" these individuals that suffered from this disorder. Bipolar Disorder is one of the oldest known illnesses that were noticed as far back as the second century. Aretaeus of Cappadocia (a City in ancient Turkey) first recognized symptoms of manic and depression and felt as if they could be linked together. Findings of Bipolar Disorder were noticed when scientist, Richard Burton wrote a book called, "The Anatomy of Melancholia" in 1650. This book focused specially on depression. Around 1000 to 1700 AD,

Bipolar Disorder seemed to diminish until the 18<sup>th</sup> and 19<sup>th</sup> century. A healthier approach to mental disorders was soon adopted.

In Burton's early work, on Etiology and Symptomatology of Chronic Illnesses, he considered manic and depression to be two forms of the same disease. The ancient Greeks and Romans coined the terms "mania" and "*melancholia*" (former name for depression) and used waters of northern Italian spas to treat agitated or euphoric patients/individuals. The spas were meant to believe that the lithium salts were to be absorbed into the body as a natural mineral. On the other hand, there was much controversy in the middle ages. Those who afflicted with this mental illness were thought to be guilty of wrongdoing and that their illness was a cause of bad deeds.

In the 1850's, measurable progress was made by French psychiatrist, Jean-Pierre Falret, who identified *folie circulaire* (circular insanity) as manic and *melancholic* episodes that were separated by symptom free intervals. He broke the academic ground when he reported distinct differences between simple depression and heightened moods. Due to Falret's work, in 1875, the term "manic-depressive psychosis" was considered a psychiatric disorder, which was then coined. Neurologist, Dr. Angst, and psychiatrist, Jules-Gabriel-Francois Baillarger also agreed with Falret and Burton's idea on mania and depression being linked with similarities, yet their term used for episodes were *folie a double forme*.

Thoughts were brought forth by writings of Swiss specialists that the history of the concept of mixed states symptoms of mania and depression occur simultaneously. The specialists believed that these ideas were probably acknowledged at the beginning of the 19<sup>th</sup> century, and named "mixtures" and "middle forms". Also in the early 1900's, after an intense research was held by German psychiatrist Emil Kraepelin; came up with separate terms of "manic-depression" and "dementia praecox" and was later named "schizophrenia" by Eugene Bleuer. Manic depression was used widespread, along with Sigmund Freud breaking new ground when he used psychoanalysis with his manic-depressive patients. Biology then received less attention when it came to childhood trauma and unresolved developmental conflicts in Bipolar Disorder.

In the early 1950's a classification system led to the term "bipolar", that differentiated between uni-polar and bipolar depression was initiated by German psychiatrist Karl Leonhard. According to Dr. Gardenswartz, "once there as a difference between bipolar and other disorders, individuals that are suffering from mental illnesses were better understood, and in turn progressed in psychopharmacology, and were able to receive better treatment. The term "bipolar", emphasizes "the two poles". This is specifically known that individuals with uni-polar depression experiences drops in mood and individuals with Bipolar Depression usually experience both depressed and elevated moods in a cyclical (arranged) manner.

Continuing with ground breaking research into lithium (a substance salt, in carbonate used in psychiatric medicines), Dr. Cade Mogens Schou, professor of the Psychiatric Hospital in Risskove, Demark and president of the International Society for Bipolar Disorders, labeled manic-depression the "national illness" of his country. Also in the 1960's, Dr. Schou used lithium on an experimental basis with a group of his patients whom suffered from mania. Dr. Schou's experiments proved that when used properly, along with proper monitoring, that lithium can be very effective in treating Bipolar Depression. Pharmaceutical companies along with other academicians were not enthused about this natural occurring mineral salt, and viewed lithium as "old news". This idea then raised alarm to the U.S. Food and Drug Administration (FDA), which then approved of lithium as a treatment of mania in 1970. In 1974, lithium was used as a preventative for manic-depressive illness. In 1980, manic-depressive disorder was replaced by Bipolar Disorder as a diagnostic term which was found in the DSMIII. Also in the 80's, research finally was able to distinguish between adult and childhood Bipolar Disorder. As of today's current research (which is never ending), studies are needed to find the probable causes and the possible methods to treat this illness. Although the combinations of choice medication (including antipsychotics, mood stabilizers, and antidepressants) support, cognitive behavioral and insight-orientated counseling/care; those tools to Bipolar Disorder has now been confronted due to the advent of lithium.

## Chapter IV

### REVIEW OF LITERATURE

#### Treatment Options

Being that Bipolar Disorder is a disorder of the brain, this disorder is generally classified as a psychiatric or mental illness. Due to this fact, a treatment plan for Bipolar Disorder primarily consists of pharmacological intervention (medications) and sometimes psychological therapy. On certain cases, psychiatric hospitals may be necessary for safety and stability purposes. Lastly, on rare occasions there are treatment options that are considered only in extreme circumstances.

Although Bipolar Disorder is viewed as a long term chronic condition, there are effective treatments available. Individuals of Bipolar Disorder often seek treatment according to what part of the cycle they are in. When an individual is in a manic or hypomanic phase, they may believe that taking their medication is no longer needed and may stop taking their medication. When an individual is in a depressive state, they often return to treatment. The primary treatment for Bipolar Disorder consists of medications called "mood stabilizers" These stabilizers are used to prevent or control episodes of mania

or depression. Many individuals may require a combination of medication to complete full remission of symptoms. This process may take some trial and error in order to find the best medication or combination for a specific individual.

Following a diagnostic evaluation, the treating clinician must determine the best treatment seeing in order to ensure the patients safety. Mood stabilizers (lithium salts) has been used as a first-line treatment for Bipolar Disorder. The intent for this type of treatment is to stabilize extreme mood swings of mania and depression. The list of these medications generally falls into these 5 categories: Anti-Anxiety and Sedatives, Antidepressants, Antipsychotics, Mood stabilizers, and Calcium Channel Blockers. With any condition of the brain, as would be expected, Bipolar Disorder directly impacts emotional and the cognitive functioning with in the individual.

Anti-Anxiety and Sedative drugs are a broad class of medication to regulate sleep, to alleviate anxiety and to help with extreme manic episodes. This includes hypnotics and benzodiazepines that are often known as tranquilizers. Despite the name Antidepressant, this drug is used to treat a wide range of other conditions besides depression (Ex: Anxiety Disorders, Obsessive Compulsive Disorder, Chronic Pain, Substance Abuse, etc) Antidepressants can be used both alone or a combination with other medications. Antipsychotics come together with a large family of medications. This drug is primarily used to treat psychotic symptoms that are most commonly found in

Schizophrenia and Bipolar Disorder diseases. One of the most important drug treatments are mood stabilizers. This drug helps to alleviate the symptoms associated with mood swings, primarily mania. This drug includes a number of Anticonvulsants and Lithium. Calcium Blockers were generally used to treat high blood pressure and irregular heartbeats or heart related issues. Later, studies prove that certain Calcium Channel Blockers are being used to treat Bipolar Disorder as mood stabilizers. One main reason for this interest is that this treatment is safer for use during pregnancy, rather than lithium or any of the anticonvulsants commonly used to stabilize moods.

Besides medication, Psychotherapy, or "talk" therapy is a very important part of treatment for Bipolar Disorder. During therapy, the individual along with therapist discusses feelings, thoughts and behaviors that cause problems in that individual's life. Talk therapy can help the individual understand and hopefully conquer any problems that may hurt their ability to function well in their life and career. This type of treatment also helps the individual to stay on their medication. Over all, Psychotherapy/Talk therapy can help the individual maintain a positive self-image. Psychotherapy also hopes to accomplish goals such as creating bonds with others who have the same condition, hopes to reduce negative behaviors and/or to learn new coping skills. The following is a list of key types of treatment therapy: Cognitive Behavioral Therapy, Dialectical Behavioral Therapy, Family/marriage Counseling, Gestalt Therapy, Group Therapy, Psychoanalytic Therapy and Talk

Therapy. On some cases, an individual may experience episodes that require 24 hour care only through psychiatric hospitalization. Hospitalizations allow specialized staff to monitor individuals closely, while changing medications necessary to achieve stabilization, and to provide concentrated frequent sessions of therapy. Hospitalizations are also vital with those struggling with thoughts of suicide. In extreme cases to the additional treatments that were previously stated, in less common circumstances, alternative treatments include: Alternative/Supplemental Therapies, Bilateral Cingulotomy, Electroconvulsive Therapy and Light Therapy.

## **Chapter V**

### **REVIEW OF LITERATURE**

#### **Criticisms/ Resistance to Treatment Compliance**

As we know, medication is a primary method of treatment for Bipolar Disorder. However, medication compliance is a major issue. When looking in terms of a definition of treatment-resistant in Bipolar Disorders, there is not a clear definition that exists. There are a number of parameters that should be considered. From the beginning, the phase of the disorder should be specified. Taking into account with most studies, these are either acute

manias or break through episodes during maintenance treatment. Definitions in these categories are generally not considered. Yet there is a criterion that is used for treatment resistant uni-polar depression that would apply such as a failure to respond to mood stabilizers as well as antidepressants. Since most definitions of treatment resistant's are symptoms and syndrome based, functional outcome is rarely considered in the definition. Another type of treatment resistance in acute episodes takes into consideration is the amount of failed responses to a specified number of treatments. To sum up the unclear definition of treatment resistance, this basically means refractors, intractable or unmanageable in the sense that the individual is not responsive to the standard treatments. This is consistent with the ongoing theory of Bipolar Disorder where as episodes become more serious and more frequent with out effective treatment. There are many factors that make this issue more complicated. The 3 main sources of confusion include: First notion to consider is the stage of illness the individual is at. It is a well known fact that some medications work best for treating mania but different medication are better for treating bipolar depression, while others are best suited for ongoing maintenance. The second conclusion is the difference between treatment resistance and treatment intolerance. It is fair to categorize someone as treatment resistance if they abandon their medication. Lastly, it is unfair to state the ineffectiveness if the individual dislikes their side affects.

There are several reasons why some individuals are not compliant when taking their medication. It also is not unusual for people with poor medication compliance to claim that “nothing works” and then presenting themselves as having treatment resistant Bipolar Disorder. In a UCLA study; their main focus was to see why individuals suffering with Bipolar Disorder do not take their bipolar medication. The top four reasons included: 1.) They disliked the idea of medication controlling their moods. 2.) They missed their “highs”. 3.) They felt depressed, and 4.) They disliked the idea of having a chronic illness symbolized by the necessity for drug therapy.

## Chapter VI

### REVIEW OF LITERATURE

#### Usefulness of Conjoint Psychotherapy

Bipolar Disorder is a treatable illness with proper medication compliance along with the individual being under the care of a physician, preferably a psychiatrist. The reason being is that manic depression starts in the brain, regulating brain hormones which then affect the neurotransmitters. Medication is the first line of therapy, and then some form of counseling is recommended. As discussed previously, Psychotherapy/Talk Therapy is a

very important part in the treatment process for the individual. Yet other therapies are equally useful. Behavior Therapy focuses on behaviors that decrease stress. This term refers to the "psycho", behavior analytical, or a combination of two therapies. This type of therapy tends to look at the more specifics such as learned behaviors, and how the environment has an impact on those behaviors. Behavior Therapy does not involve one specific method but it has a wide range of techniques that is used in treatment. Cognitive Therapy is helpful for the individual by helping them to learn to identify and modify the patterns of thinking that accompany mood swings. Cognitive Therapy is an effective treatment for anxiety, depression and severe stress. Stress may not be the only contributing factor to mood disorders or unpleasant feelings that are interfering with a happy life style. In essence, a mix of Behavioral and Cognitive Therapy can be a very effective mode of treatment. Cognitive Therapy for stress rests on the premise that it's not the events in our lives that causes us stress, rather the stress comes from how we think and how we view those events. Virtually, all of the thought patterns that negatively impact the individual's experiences can be categorized into one of ten common cognitive distortions (All-or-Nothing Thinking, Overgeneralization, Mental Filter, Disqualifying the Positive, Jumping to Conclusions, Catastrophizing, Emotional Reasoning, "Should" Statements, Labeling and Mislabeled and Personalization). The combination of Cognitive Therapy and Antidepressants has shown to be effective in managing severe or chronic

depression. This therapy has also proven to be beneficial to individuals whom have only a partial response to antidepressants.

Interpersonal Psychotherapy involves relationships and aims to reduce strains that the illness may place upon them. This therapy is a time-limited therapy that encourages the individual to regain control mood and functioning typically lasting 12-16 weeks. The common factors that this therapy is based on: a "treatment alliance in which the therapist empathically engages the individual, helps the individual to feel understood, arouses affect, presents a clear rationale and treatment ritual, and boosts success experiences". Another type of psychotherapy for Bipolar Disorder is Social Rhythm Therapy. This therapy helps the individual to develop routines and to maintain these routines. Interpersonal and Social Rhythm Therapy work hand in hand; and is one of the only therapies shown to be effective for Bipolar Disorders specifically. These two therapies attack the body, mind and heart. One of the main suggestions in this therapy is journaling. The individual will keep track of daily activities (ex: when they wake up, when they sleep, what time they eat, what time they interact socially, whether those interactions were positive or negative, and so on.) The purpose of this exercise is to identify which habits and patterns may be exacerbating the individual's Bipolar Disorder.

## Chapter VII

### CONCLUSIONS AND RECOMMENDATIONS

In conclusion, Bipolar disorder is a mental illness highlighted by alternating episodes of mania and depression; euphoric highs and desperate lows. It's an emotional disorder which is frequently overlooked by the individual, his or her friends and family, and sometimes even by mental health professionals who are prone to misdiagnosis. And perhaps the most frightening fact is that the suicide rate during a manic depressive episode is higher than it is for any other mental illness. More than 25.7 million Americans suffer from bipolar disorder, and these are just the people who are diagnosed. There are as many as 5 million more that may not be currently diagnosed. Bipolar disorder is an invisible illness, and sometimes the stigma of having it is almost as bad as the disorder itself. Medication in conjoint psychotherapy is a must in treating an individual with a Bipolar Disorder. Medication is for maintenance purposes, while a form of psychotherapy is useful for the individual to learn how to function accordingly in daily activities. There is no cure for Bipolar Disorder, but the treatment options are significantly helpful for those living with this disorder. The most important notion to remember is that Bipolar Disorder is an illness, a long-term preventative treatment is highly recommended. Neither

therapy, nor medication can be left out. A combination of medication and psychosocial treatment tends to be the most effective treatment. Consistency in treatment will result in a more positive outcome.

It is recommended that the individual, who has been correctly diagnosed with Bipolar Disorder, should meet with a psychiatrist or medical professional to be evaluated for psychotropic medications. Those medications are referred to "mood stabilizers." It is also recommended that the individual meet with a therapist for individual, family and/ or group counseling. "Talk" therapy can be useful in areas providing support, education needs, and for individual guidance in dealing with this disease. Therapy can also help increase mood stability, decrease the number of hospitalizations and improve functioning in various areas.

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